Colostomy Care

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• Psychic preparation of the patient for the necessity of colostomy is a long first step toward his adjustment to living with an artificial anus. Proper surgical placement of the outlet will ease care of the bowel. Control of fecal consistency and peristaltic rate should ideally produce constipation responsive only to habit or enemata. The object of the enema is to produce an evacuation thorough enough to prevent soiling for a day or two. The object of dietary variations is to produce a manageable volume and consistency of fecal stream. The technique of enemas and choice of diet can be individualized when the underlying principles are understood.

OPTIMAL CONTROL of function of the artificial anus and the bowel after colostomy depends upon maintaining proper consistency of the feces and peristaltic rate and upon a desirable constipation responsive to habit or enema.[3] Attention to many minor details—each alone perhaps seemingly unimportant—is necessary for the achievement of these results.

Since the patient's attitude toward colostomy is a great factor, a tactful approach to the matter by way of psychic preparation, before the operation is done, is indicated. Most patients should be told that the proposed operation may entail colostomy. However, the unexpected suggestion of colostomy at the first visit will often stampede a patient. It is usually wiser not to mention the possibility of colostomy until after the patient is hospitalized and has established some confidence in the physician. It is best to discuss colostomy as a procedure that will be used only if absolutely necessary. The patient should be so firmly convinced that, if the operation is done, he will have no lingering doubt as to whether or not it had to be done.

Many laymen have the idea that colostomy is always associated with fatal cancer, or have heard of "messy" palliative colostomy in helpless patients with constantly upset bowels. Without details, the first discussion should create the expectation that the patient will be quite able to live normally and to care for the disposal of feces himself. It is often useful to mention that many people, including senators, singers, actors and athletes are well adjusted to colostomy.

POSITION OF ARTIFICIAL ANUS

An excellent discussion of indications and techniques for colostomy has been presented by Wiley and Sugarbaker.[3] Placement should be preoperatively considered with the patient standing so that the surgeon may observe where on the abdomen a dressing will fit smoothly and be easily accessible to the reach and vision of the patient. Possible loss in weight and unusual occupational activities should be anticipated, as well as the type of clothing or possible desire to wear swimming trunks. A low opening sometimes interferes with sexual intercourse. A periumbilical position might better be avoided if the patient has a deep navel. Incisional herniae, dehiscence and wound infections are dangers in bringing the bowel through the incision. Probably the muscle splitting stab wound in the left lower quadrant is the most common placement.

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SURGICAL TECHNIQUE TO FACILITATE CARE

The hole in the abdominal wall must be just the correct size to make either herniation or stenosis unlikely. Suturing of the bowel wall to the peritoneum, fascia or skin is better avoided owing to the possibility of fistulae from the stitches. At the completion of the operation the stoma should be left an inch and a half above the level of the skin so that after postoperative contraction it will be just about a half-inch above the skin level. If the subcutaneous fat is excessively thick, the skin about the stoma can be "umbilicated" by tacking the skin to the underlying fascia with a few interrupted sutures. A stump that looks perfect at the operating table will probably shrink and be too small later, whereas an error on the generous side can be corrected later by trimming in the office. It is easier to free the bowel to provide adequate exteriorization at the time of operation than it is to correct retraction of the stoma.

For the surgical dressing, vaseline gauze wrapped around the external stump of bowel should be placed in such a way that only the top layers need be disturbed to create the vent when the stoma is opened. Even though apparently soiled, these sealed underlayers of vaseline gauze upon the serosa and skin edges can remain adherent for several days. This

wrapping of gauze serves to maintain the bowel in position while it seals and heals to the abdominal wall. A similar function is served by the clamp, on an end colostomy, which is left incorporated in the dressings.

POSTOPERATIVE CARE

In cases of obstruction of the bowel, a catheter may be placed immediately after operation to permit decompression. Usually, however, the opening is not made until 48 hours later. By then, in most cases, sealing of the peritoneum and of the edges of the wound has taken place. An even greater length of time may elapse if there is no indication of the development of obstruction. The external portion of bowel should be glanced at daily to note its color and to make sure it has not slipped back inside. With loop colostomy, the presenting antimesenteric border of the bowel may be opened with cautery to seal bleeding points. Occasionally ligation of a bleeding vessel is necessary. With proper preoperative preparation of the bowel, there is usually no need for irrigating after colostomy before the fifth or sixth day. However, if preparation was inadequate or the bowel was obstructed at the time of operation, irrigation a day after the opening may be desirable. The first irrigation is best performed by a physician or a thoroughly experienced nurse. With the patient lying on the left side, a large well-lubricated catheter is inserted gently to a depth of six inches or so. It cannot be forced, for danger of perforation definitely exists. If the catheter will not pass a fold of mucosa, water run through it will usually open the way ahead. Some sort of cuff (such as an inverted rubber nursing nipple) around the catheter may be necessary to prevent reflux spilling of the water. In the first few days it is not essential to continue enemas until all the contents of the bowel are evacuated.

Some surgeons administer a cathartic on the third to fifth postoperative day when the patient is accepting feedings. This liquefies the feces and overcomes inertia of the bowel induced by narcotics and ileus.

THE COLOSTOMY ENEMA

As soon as possible the patient should be taught to care for his own bowel, the nurse doing no more than handle the equipment and supervise. The enema should be given at the same time each day in order to establish a habit, the time of day chosen being one that will be convenient for the patient after returning home. Usually no more than a pint of fluid administered once or twice is necessary. Although the first irrigations are given with the patient in bed, it is soon more satisfactory for him to use commercial irrigating equipment while sitting on a chair before the open toilet. After the patient has cared for himself for a few days, he then should carry out the procedure while the physician watches to point out errors or demonstrate improvements and modifications in technique.

The object of the enema is to produce a reflex evacuation of the entire colon, ideally even of the cecum. It is not necessarily intended to wash out the entire cecum. The evacuated bowel will then store without emptying for another 24 to 48 hours. However, in some cases the bowel will not be satisfactorily emptied for long enough with a simple stimulating irrigation. Adequate cecal cleansing may require a high enema through an inflated Foley catheter which is collapsed and withdrawn after the cecum has been filled with water. At first it takes about an hour to give an enema through the artificial anus and completely evacuate the bowel, but later the patient learns to wear a bag after the enema to collect the discharge in less than an hour. After evacuation, the patient should feel secure with only a small dressing or Kleenex beneath an elastic girdle. If protracted delay between administration and return of the enema occurs, a little soapsuds may be added to the water. Cramps may result if the water is injected too rapidly or is too cool.

With an artificial anus, constipation is desirable so that evacuation occurs only by some habit-reflex or with an enema. Some patients develop such spontaneous regularity that irrigations are not needed. Many need the enema daily whereas others can go as long as two or three days between enemas without soiling. It is best to commence with daily irrigations and gradually increase the interval as the bowels become regulated and the contents solid. In rare patients with an irritable bowel, soiling several times daily may persist despite all efforts. In these cases a daily high enema should be continued and a dome or bag worn in the interval. The only exception to the rule against laxatives is the case of the rare person in whom the bowel contents become so firm that, despite enemata and liquids by mouth, the feces still are inspissated.

DIET

Manageable consistency and volume of fecal stream is the objective of diet. Most patients are finally able to return to their customary diet. A few always have to avoid any but constipating foods and milk, refined cereals, cheese, fish, beef, bread, potatoes, macaroni, rice and foods that have little indigestible residue. Such foods as fresh fruits and juices, green vegetables, whole cereals and breads, cabbage, beans and corn produce considerable residue or are laxative and should be avoided until the patient learns by adding one at a time what can be tolerated. Certain fruits and juices may increase peristalsis and should be used only when the stools

get too hard. Prohibited foods (which usually interfere with regularity) include spices, uncooked or fibrous vegetables, iced or carbonated beverages, all fried foods and usually pork, veal and duck.

Peristaltic activity and the time taken for foods to pass through the gastrointestinal tract depend much upon diet. Diminution of peristalsis can be accomplished when necessary with cholinergic drugs such as amphetamine sulfate administered postprandially so as not to interfere with the appetite.

CARE OF STOMA AND SURROUNDING SKIN

During the first postoperative weeks, the exposed serosa and mucosa may be very friable and bleed upon removal of dressings. Hence fine-mesh vaseline impregnated gauze is preferred. If cellulitis develops around the stoma, it is treated with warm, moist compresses and antibiotics, and the removal of any stitches restricting drainage.

Unless there is diarrhea there is usually no irritation of the skin about the artificial anus formed by colostomy. Should cutaneous irritation develop, cleanliness, exposure to air and the use of an ointment containing thymol iodide or a silicone is ordinarily effective. Inability to control flatus may be made less embarrassing by consumption of charcoal tablets or chlorophyl. Herniation of the stoma or of the area about it, if bothersome, can be reduced and held inverted by a bulky pad worn beneath a corset or supporter. If manipulation is necessary to keep the stoma adequately dilated, the patient or a relative can be taught to insert an index finger into the opening once or twice a week. If strictures occur they are almost always at the mucocutaneous junction, and surgical correction is necessary. Usually the operation is relatively minor and it should not be postponed so long that the opening becomes so small that more extensive revision is demanded.

INFORMATION TO PATIENT

Minimum instructions to the patient should include the information listed below. (They should be provided in writing if the patient has difficulty in remembering or understanding them.)

1. Irrigate with a quart of lukewarm tap water at least once a day at a regular time. The container should be elevated about a foot above the level of the opening in the abdomen. A lubricated catheter should be inserted slowly and gently six to eight inches and the water allowed to run in slowly. When all the water has run in, the catheter should be removed and at least 30 minutes allowed for the returns to be expelled.

2. After the enema has evacuated, do not wear a colostomy bag. Cover the abdominal opening with Kleenex held in place by a wide elastic abdominal band or girdle.

3. Keep the colostomy opening wide by inserting the index finger past the second joint about twice a week. (Rubber finger cots can be purchased at the drug store for this purpose.)

4. Take no laxatives. Avoid fruits which produce bowel irritations or looseness, such as certain raw fruits, beans, corn and spices. If the feces are too hard, drink more water.

5. Remember that ideally the bowel should remain constipated and evacuation should occur only when it is expected to or when irrigation is carried out.

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